Abortion: It is time for doctors to get off the fence

In response to Dr. Myre Sim's shopworn fulminations (*Can Med Assoc J* 1988; 138: 742–743), I am one doctor who has been off the fence and on firm ground for some time on the matter of abortion.

I expect that most physicians in Canada have a highly developed ethical sense and have welcomed the thoughtful, humane document that is the Supreme Court's 150-page judgement in the Morgentaler case. To have a highly developed ethical sense is not antithetical to remaining publicly silent. Rather, it may be that one is struck with the complexity of problems that do not have simple solutions.

None the less, I agree with Dr. Sim that physicians, through the voices of their associations, should evolve a coherent ethical policy statement on abortion, one that can satisfy the intellectual honesty of proponents of both ends of the spectrum. Then we will not be constantly subject to the exceedingly irritating and facile charge that we do not respect human life. We need a policy that sets out the proportionality between the needs of women in a secular democratic society to be treated as individuals whose dignity and freedom are undeniable and the needs of a humane society that feels an increasingly urgent need as gestation unfolds to protect the developing fetus.

Such a policy would avoid the on/off-switch approach to fetal rights, which would have us ground the moral standing of the human organism as an existential pop-out-of-nothingness occurring at conception. It would likely result in a formulation that would parallel current practice, wherein the termination of a pregnancy in the early weeks of gestation will not be seen as an ethical calamity and, like other matters of contraception, menstrual dysfunction and pregnancy for which women require medical attention, will be funded under medicare. It would see increasing scrutiny of midtrimester abortion (quite welcome to "pro-choice" doctors, I expect) and perhaps would invite input from lay ethicists, particularly in the area of the termination of pregnancy because of nonlethal chromosome syndromes diagnosed by amniocentesis.

The key to reducing the problem of ethically troublesome abortions remains quick, easy access to abortion, which includes improvement in the early identification of genetic defects. The key to reducing the numbers of abortions includes increasing awareness of the still dire need of children for information about sex, sexuality and birth control and increasing promotion of ethics as an object of study in school.

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Chronic obstructive pulmonary disease

Dr. Nicholas R. Anthonisen has provided a review of his personal regimen for the treatment of chronic obstructive pulmonary disease (COPD) (*Can Med Assoc J* 1988; 138: 503–510). His article does not represent "Recent Advances in Pharmacotherapy", for there is little new in his therapeutic approach.

Although I believe that most physicians would agree in general with Dr. Anthonisen, I take exception to his comment in the abstract that "smoking cessation is probably important, although its benefit in established COPD is unproven". In Anthonisen's opinion smoking cessation may not be proven beyond any reasonable doubt by the scientific method, but Fletcher and colleagues' classic work,[1] referenced by Anthonisen, shows that when a former smoker gives up the habit the rate of decline in the forced expiratory volume in 1 second eventually slows to a point approaching that of nonsmokers. This may be insufficient for Anthonisen to consider as categorical proof; however, it is unfortunate when rigid dedication to scientific proof precludes common sense. I therefore feel that it is irresponsible for Anthonisen to include the word "probably" in connection with the benefit of smoking cessation.

In his introductory remarks Anthonisen states that his paper is limited to the outpatient management of COPD. He makes no comments about active rehabilitation, which has been shown to be of benefit in our centre[2,3] and others and which I consider to be of great value in outpatient management. Through a concentrated rehabilitation course[4,5] patients can be provided with the information and incentive to take more responsibility for their health. Most require an intensive program[6] to be able to understand and manage more effectively their therapy, which, as Anthonisen illustrates well, can be very complicated.

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References

1. Fletcher C, Peto R, Tinker C et al: *The Natural History of Chronic Bronchitis and Emphysema*, Oxford U Pr, London, 1976

2. Arkinstall W, Atkins M: Chronic obstructive lung disease; rehabilitation and use of home oxygen. *BC Med J* 1984; 26: 661–664

3. Hudson LD, Pierson DJ: Comprehensive respiratory care for patients with chronic obstructive pulmonary disease. *Med Clin North Am* 1981; 65: 629–645

4. Lertzman MM, Cherniak RM: Rehabilitation of patients with chronic pulmonary disease. *Am Rev Respir Dis* 1976; 114: 1145–1165

5. Roselle SR, D'Amico FJ: The effect of home respiratory therapy on hospital re-admissions rate of patients with

chronic obstructive pulmonary disease. *Resp Care* 1982; 27: 1194-1199

6. O'Ryan JA, Burns DG: *Pulmonary Rehabilitation from Hospital to Home*, Year Bk Med, Chicago, 1984

[Dr. Anthonisen responds:]

I used the word "probably" because smoking cessation has *not* been shown to be of benefit in established COPD. The Fletcher data, which I agree are compelling, were acquired in a healthy working population, not patients, and therefore cannot be applied with complete confidence to patients. Further, in no study of lung disease has smoking cessation been applied in a random way; that is, data for people who spontaneously stopped smoking have been compared with data for those who did not. Obviously there may be differences between these groups other than the subsequent influence of smoking. For example, the people who stop may be sicker than those who do not.

I did not discuss rehabilitation because the topic was pharmacotherapy, and it is my impression that "rehabilitation" implies more than pharmacotherapy. However, this is a muddy area. First, the term "rehabilitation" can be defined in various ways, and its use is not helpful unless a specific program is described. Second, there has been very little careful, controlled evaluation of rehabilitation programs, and it is therefore difficult to regard their benefit as established. Along this line, I recommend to Dr. Arkinstall an excellent paper by Guyatt and associates.[1]

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Reference

1. Guyatt GH, Berman LB, Townsend M: Long-term outcome after respiratory rehabilitation. *Can Med Assoc J* 1987; 137: 1089-1095

Retirement age in the forces

In his article "Not willing to be 'figurehead', surgeon general quits armed forces" (*Can Med Assoc J* 1988; 138: 541, 545-547) Patrick Sullivan reports that "defence department data reveal that medical officers are in short supply".

At the same time, the compulsory retirement age regulations force medical officers who would like to continue serving in the Canadian Armed Forces to quit upon reaching the age of 55 years. Civilian doctors are hired at high cost to the taxpayer to do work that rightfully should be done by military physicians. The Soviets had chiefs of defence staff in their 70s, and the Americans had admirals in their 80s, but in Canada one is considered too old at 55, although one is kept on the Supplementary Reserve list till age 65 — For what purpose? one might ask.

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[The new surgeon general replies:]

A study of age limitations in the Canadian Forces was carried out in 1980 to rationalize the various age criteria for enrolment, training, career advancement and retirement. Fifty-five years was selected as an appropriate retirement age in that it was a reasonable compromise between the conflicting requirements for fitness on the one hand and long service on the other.

Although some individuals are perfectly fit to serve beyond age 55, it would be imprudent to base retirement policies upon exceptional cases. Furthermore, because medical officers are required to provide direct support to forces in the field, it cannot be argued that the release age of 55 should not apply to them as well.

Other armed forces permit service beyond age 55, but that decision was not necessarily the result of extensive study or even deeply held conviction. In any event, age has less effect on departure than does pension policy. The United States, for example, made retirement after 35 years of service so attractive that few serve further.

Canadian Forces medical officers who enrolled after unification (in 1968) and before introduction of the specialist officer career development plan (in 1987) or who exercised a one-time conversion option at the time of introduction of these terms of service are permitted to serve beyond age 55 in the rank of colonel and above. Currently serving colonels and general officers (and, indeed, the many majors and lieutenants-colonels who had served more than 20 years when the new terms were offered to specialist officers) will remain subject to the retirement ages of 58 and 60. So the retirement age of 55 for colonels and general officers is not likely to have any impact for quite a number of years.

Extending the time that officers spend in senior ranks may help alleviate the current shortage of medical officers, but in the long run it may be detrimental to the service, in that it would stifle promotion of highly capable officers. Careers of younger officers need to be developed at each intervening rank, which demands the ability to plan. We cannot do succession planning in these circumstances without a strong measure of control over retirement.

Although the policy is to proceed to one's compulsory retirement age, those on terms that permit service past age 55 will have that right honoured, and those whose terms will expire before age 55 may be offered an extension to age 55. Furthermore, in recognition of current shortfalls, this policy has been interpreted as liberally as possible, and extensions have been authorized up to immediately before the 56th birthday.

With respect to the Supplementary Reserve, members are

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